STATE OF CALIFORNIA
DEPARTMENT OF CORRECTIONS
OSS 07C (12/03)

OFFICE OF SELECTION AND STANDARDS

PEACE OFFICER VISION VERIFICATION

FOR SURGERY, UNCORRECTED VISION EXCEEDS 20/60, OR CONTACT LENSES WEARER

Candidate's Name: _____
PRINT *Last* *First* *MI*

Address: _____ **SSN:** _____
Street

Telephone Number: ( )
_____
City *State* *ZIP*

CLASSIFICATION: **(Circle One)** **CO** **MTA** **CCI** **PAI**

AUTHORIZATION TO RELEASE INFORMATION

To determine my eligibility for employment as a Peace Officer with the California Department of Corrections (CDC), I authorize you to release to CDC any and all medical information and/or records concerning my vision. This authorization is valid until the selection process is completed.

Candidate's Signature: _____ **Date:** _____

TO OPTOMETRIST/OPHTHALMOLOGIST:

Your patient has applied for a Peace Officer position with CDC and we need verification that his/her vision meets our corrected vision requirements. We also require disclosure of the means of correction. Please evaluate your patient's visual acuity and indicate both corrected and uncorrected levels of acuity in the designated area below. The information provided will normally be used by non-medical staff; therefore, in addition to listing the acuity measurements, all questions must be answered.

1. Has the patient had refractive eye surgery (i.e., RK, PRK, Lasik, etc.) within the last 12 months? Yes ❑ No ❑
   If "Yes", indicate date of last surgery: _____
2. Is the patient's visual acuity 20/20 or better in each eye uncorrected? Yes ❑ No ❑
3. If the patient's visual acuity is not 20/20 or better in each eye uncorrected, is his/her visual acuity corrected to 20/20 in each eye? Yes ❑ No ❑
4. What method of correction does your patient currently use? Check one: Glasses ❑ Hard/Semi Rigid contact lenses ❑ Soft contact lenses ❑
   If contact lenses are used, has your patient been a successful contact lenses wearer for the last 12 months? Yes ❑ No ❑
5. If "No", indicate the date the patient began using contact lenses: _____
6. Document the patient's uncorrected visual acuity?

   Right eye: _____ Left eye: _____ Both eyes: _____
7. In the section below, please complete the prescription information for the correction Item 3.

Glasses						Contact Lenses			
Rx		Sphere	Cylinder	Axis	Prism	Rx	Power	Base Curve	Diameter
DIST	OD					OD			
	OS					OS			
ADD	OD	+	Bifocal Type						
	OS	+	Trifocal Type						

Doctor's Original Signature	Date
Doctor's Printed Name	Telephone Number
Doctor's Address City, State ZIP	

Doctor, please mail the completed form no later than _____ to:

DEPARTMENT OF CORRECTIONS
NORTHERN SELECTION CENTER
2201 BROADWAY
SACRAMENTO, CA 95818-2572